King County

Benefits Open Enrollment for 2006

PT 587 Partial Benefits Plan Guide

With Information for PERS Plan 2 Grandfathered Employees

- **Read the overview of new part-time Local 587 benefits plans.**
- Review each section of your open enrollment (OE) form with the corresponding section in this guide.
- If you make changes or pay premiums before-tax and want to continue doing so in 2006, you must return your OE form *by Friday, October 28*, to Benefits and Retirement Operations, Exchange Building EXC-ES-0300, 821 Second Avenue, Seattle WA 98104-1598.
- No changes? Simply keep the form for your records.
- Questions? Contact the resources listed in the Resource Directory or call 206-684-1556.

Section **Page**

This guide describes certain key features and provides brief summaries of your benefit plans. However, it does not provide detailed descriptions. If you have questions about specific plan details, refer to the plan booklets available at http://www.metrokc.gov/employees/benefits/health_and_insurance/regbooks.aspx or from Benefits and Retirement Operations, or contact the plans. We've made every attempt to ensure the accuracy of the information in this guide. However, if there is any discrepancy between it and the insurance contracts or other legal documents, the legal documents will always govern.

Call 206-684-1556 for alternate formats.

An Overview of Part-Time Local 587 Benefits Plans

This is the last year there will be three benefits plans – Plan 1, Plan 2 and Plan 3 – for part-time transit operators. Beginning January 1, 2006, there will be only two plans: the current Plan 2 with fully paid benefits for eligible part-time operators (renamed the Full Benefits Plan), and a single plan for part-time operators who work less than half-time and have not become eligible for fully paid benefits, called the Partial Benefits Plan. If you are in Plan 1 or Plan 3 at the end of 2005, you will automatically be enrolled in the single benefit plan called Partial Benefits Plan – that is why you've received this open enrollment guide.

The following information is provided to help you understand the basics of the two plans that become effective January 1, 2006. You are provided enrollment materials for each plan as you become eligible. Contact your base chief if you have questions regarding your eligibility.

► Partial Benefits Plan for employees who work less than half-time *(the single benefits plan replacing Plan 1 and Plan 3)*

Effective January 1, 2006, you become eligible for the Partial Benefits Plan the first of the month following your qualification or hire date (whichever is later) or if you are in Plan 1 or Plan 3 on December 31, 2005. Your hire date is determined by your department. If your qualification or hire date is the first of the month, you become eligible that same day.

Under the Partial Benefits Plan, you may purchase medical, dental and vision coverage for you and the eligible family members you enroll (the employee's medical, dental and vision coverage is partially subsidized by the county). If you elect medical coverage, you receive fully paid basic life, accidental death and dismemberment (AD&D) and long term disability (LTD) insurance, and you may purchase enhanced life and AD&D for you and your family members and enhanced long-term disability for you. However, enhanced life and enhanced LTD are not available to you if you have previously declined them under a previous part-time Local 587 benefits plan.

► Full Benefits Plan *(formerly Plan 2)*

You become eligible for the Full Benefits Plan through 2006 in any of the following ways:

- You are currently eligible for Plan 2 benefits (Plan 2 eligibility extends through December 31, 2006)
- You receive 338 paid hours in the four-month period of March 1-June 30, 2005 (fully paid benefits begin September 1, 2005, and extend through December 31, 2006)
- You pick 4 or more hours in the 2005 fall shakeup or the spring or summer shakeups of 2006 (fully paid benefits begin the first day of the month after you work the 4 or more hour assignment and extend through December 31, 2006)
- You receive 1,019 or more paid hours in the 26 pay periods ending August 12, 2005 (fully paid benefits begin January 1, 2006, and extend through December 31, 2006).

Under the Full Benefits Plan, you receive county-paid medical, dental and vision coverage for you and the eligible family members you enroll, plus basic life, AD&D and long term disability (LTD) insurance for you.

When first enrolling in the Full Benefits Plan before 2006, you may purchase enhanced life and AD&D for you and your family members, plus enhanced LTD for you, because these benefits were not previously available to you. Beginning in 2006, if you decline enhanced life and enhanced LTD when you first become eligible for them under the Partial Benefits Plan, you may not add them when you become eligible for the Full Benefits Plan.

1 Premium payment plan

If you elect Partial Benefits Plan coverage, you pay premiums through payroll deduction. The monthly cost of your coverage is divided in half and deducted from your two regular monthly paychecks (when there are three paychecks in a month, no deductions are taken from the last one).

The premiums for health coverage (medical, dental and vision) for you and your family members may be deducted before-tax or after-tax.

If you have health coverage premiums deducted before-tax, this reduces your taxes, but IRS restrictions apply:

- Any portion of the premiums you pay to provide health coverage to a domestic partner (DP) or DP's children is deducted after-tax
- You may not drop any health coverage until the next open enrollment unless due to a qualifying event:
  - Death of a family member
  - Divorce/dissolution of a domestic partnership
  - Child loses eligibility
  - Significant change in your spouse's/domestic partner's coverage due to his/her employment
- You must re-enroll for the before-tax premium payment plan every year during open enrollment or you default to the after-tax plan.

If you have health coverage premiums deducted after-tax, you do not reduce your taxes, but may drop the coverage for yourself or a family member anytime.

The premium payment plan you have now is shown on your OE form, but you need to check a box to indicate how you'd like your health premiums deducted in 2006. If you don't check a box, you're automatically enrolled in the after-tax premium payment plan for 2006 (even if you have the before-tax plan now).

2 Medical

The medical coverage you have now is shown on your OE form. The medical plan you elect is the one your covered family members have. If you want to change your coverage, check the appropriate boxes.

The following table shows the monthly premiums for the three medical plan options. 2006 and 2005 premiums are shown so you can see how premiums compare year to year.

Sp = Spouse DP = Domestic Partner Ch = Children

Monthly Premiums	You Only	You + Sp	You + Ch	You + Sp/DP + Ch
KingCare℠ Basic				
2006 ($ 249.14 paid by county)	$ 109.39	$ 467.92	$ 396.22	$ 754.75
2005 ($ 248.90 paid by county)	$ 88.70	$ 426.30	$ 358.78	$ 696.38
KingCare℠ Preferred				
2006 ($ 249.14 paid by county)	$ 176.68	$ 602.50	$ 517.34	$ 943.16
2005 ($ 248.90 paid by county)	$ 152.37	$ 553.64	$ 473.38	$ 874.65
Group Health				
2006 ($ 249.14 paid by county)	$ 62.28	$ 373.70	$ 311.42	$ 622.84
2005 ($ 248.90 paid by county)	$ 62.22	$ 373.41	$ 310.57	$ 622.23

The next table summarizes the features and covered expenses of the three medical plan options. As you compare the KingCare[SM] Basic and Preferred plans, please note that the Basic plan is essentially the same as the Preferred plan, but with higher annual deductibles and coinsurance. This makes the Basic plan less expensive for employees like you who must pay monthly premiums for medical coverage.

Also please note that two separate companies process claims for the KingCare[SM] plans. If you choose a KingCare[SM] plan, you receive a medical card from Aetna to use for all medical claims (physician visits, hospital, lab work, etc.) and a prescription card from Caremark (formerly AdvancePCS) to use for all outpatient, retail pharmacy and mail order prescription drug claims. If you are in a KingCare[SM] plan and still have an AdvancePCS prescription card, your AdvancePCS card remains valid.

Feature/Covered Expense	KingCare[SM] Basic	KingCare[SM] Preferred	Group Health
Provider choice	You may choose any qualified provider, but you receive higher coverage when you use network providers	You may choose any qualified provider, but you receive higher coverage when you use network providers	You choose a Group Health primary care physician (PCP) who provides and coordinates most services through the Group Health network; you may also self-refer to Group Health staff specialists; no non-network coverage unless indicated
Annual deductible	$500/person, $1,500/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible	$100/person, $300/family Deductible amounts applied to charges incurred in the last 3 months of the calendar year are carried over and applied to the next year's deductible	None
Copay/office visits	No copays, but you pay coinsurance	No copays, but you pay coinsurance	You pay $20
After the deductible/copays, the plans pay most covered services at these levels until you reach the annual out-of-pocket maximum	80% network medical claims (you pay 20% coinsurance) 60% non-network medical claims (you pay 40% coinsurance)	90% network medical claims (you pay 10% coinsurance) 70% non-network medical claims (you pay 30% coinsurance)	100% network Limited emergency/out-of-area non-network care
Annual out-of-pocket maximum	$1,200/person, $2,400/family network (plus deductible) $2,000/person, $4,000/family non-network (plus deductible)	$800/person, $1,600/family network (plus deductible) $1,600/person, $3,200/family non-network (plus deductible)	$1,000/person, $2,000/family network and limited emergency/ out-of-area non-network
After you reach the out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	100% network	100% network	100% network
Lifetime maximum	$2,000,000	$2,000,000	No limit

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)	80% network 60% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits	90% network 70% non-network Certain services must be prescribed by a physician; Aetna reviews medical necessity of all treatment after 20 visits	Self-referrals to a network provider are covered up to 8 visits/medical diagnosis/ calendar year for acupuncture and up to 3 visits/medical diagnosis/calendar year for naturopathy; except for chiropractic services, all other alternative care may require PCP referral All services are subject to the $20 copay/visit
Ambulance services	80%	90%	80% (except hospital-to-hospital ground transfers covered 100% when initiated by Group Health)
Chemical dependency treatment	80% network 60% non-network $12,500 (2005)/$13,000 (2006) maximum/24 consecutive months for combined network and non-network services when preauthorized (maximum subject to annual adjustment)	100% network 70% non-network $12,500 (2005)/$13,000 (2006) maximum/24 consecutive months for combined network and non-network services when preauthorized (maximum subject to annual adjustment)	100% after $200 copay/admission for inpatient care 100% after $20 copay/visit for outpatient care $12,500 (2005)/$13,000 (2006) maximum/24 consecutive months (maximum subject to annual adjustment)
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	80% network 60% non-network Up to 33 visits/year for combined network and non-network services	90% network 70% non-network Up to 33 visits/year for combined network and non-network services	100% after $20 copay/visit
Diabetes care training	80% network when prescribed by your physician 60% non-network when prescribed by your physician	90% network when prescribed by your physician 70% non-network when prescribed by your physician	100% after $20 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	80% when preauthorized	80% if authorized in advance by a network provider as medically necessary
Emergency room care	80% after $50 copay/visit (waived if admitted) for network or non-network emergency care 80% network, 60% non-network after $50 copay/visit for non-emergency care	90% after $50 copay/visit (waived if admitted) for network or non-network emergency care 90% network, 70% non-network after $50 copay/visit for non-emergency care	100% after $75 copay/visit to network facility ($75 copay is waived but $200 copay/ admission for hospital care applies if admitted) 100% after $125 copay/visit to non-network facility ($125 copay is waived but $200 copay/ admission for hospital care applies if admitted) Non-emergency care not covered

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Family planning	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit (infertility treatment not covered)
Hearing aids	100% up to $500 in 36 months for combined network and non-network services	100% up to $500 in 36 months for combined network and non-network services	100% up to $300/ear in 36 months
Home health care	100% when preauthorized up to 130 visits/year for combined network and non-network services	100% when preauthorized up to 130 visits/year for combined network and non-network services	100%
Hospice care	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period	100% when preauthorized Certain limits apply; call plan for details
Hospital care (not in an emergency room)	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized	100% after $200 copay/admission
Lab, x-ray and other diagnostic testing	80% network 60% non-network	90% network 70% non-network	100%
Maternity care	80% network 60% non-network	90% network 70% non-network	100% for delivery and related hospital care after $200 copay/admission 100% after $20 copay/visit for prenatal and postpartum care
Mental health care	80% network, 60% non-network for inpatient up to 30 days/year (combined network and non-network services) 80% network, 60% non-network for outpatient up to 52 visits/year (combined network and non-network services)	90% network, 70% non-network for inpatient up to 30 days/year (combined network and non-network services) 90% network, 70% non-network for outpatient up to 52 visits/year (combined network and non-network services)	100% after $200 admission copay per visit, up to 12 days/year for inpatient 100% after $20 copay/individual, family, couple or group session, up to 20 visits/year for outpatient
Neurodevelopmental therapy for covered family members age 6 and under	80% network when preauthorized 60% non-network when preauthorized $2,000/year maximum for combined network and non-network services	90% network when preauthorized 70% non-network when preauthorized $2,000/year maximum for combined network and non-network services	100% for inpatient services after $200 copay/admission up to 60 days/year (combined with rehabilitative services) 100% after $20 copay/visit for outpatient services up to 60 visits/year (combined with rehabilitative services)
Out-of-area coverage while traveling, for your children away at school, etc.	Same coverage as when home, through Aetna and Caremark national provider networks	Same coverage as when home, through Aetna and Caremark national provider networks	Reciprocal benefits available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out-of-area
Physician and other medical/surgical services	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Prescription drugs – up to 30-day supply through network pharmacies	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) (Prescriptions filled at non-network pharmacies reimbursed at the rate Caremark pays to network pharmacies, less your copay)	100% after $10 copay for generic 100% after $15 copay for preferred brand ($20 if generic available, but if unable to take it for medical reasons, the $15 copay applies) 100% after $25 copay for non-preferred brand ($30 if generic available, but if unable to take it for medical reasons, the $25 copay applies) (Prescriptions filled at non-network pharmacies reimbursed at the rate Caremark pays to network pharmacies, less your copay)	100% after $10 copay for generic 100% after $20 copay for preferred brand 100% after $30 copay for non-preferred brand (No reimbursement for prescriptions filled at non-network pharmacies)
Prescription drugs – up to 90-day supply through network mail order	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take it for medical reasons, the $50 copay applies)	100% after $20 copay for generic 100% after $30 copay for preferred brand ($40 if generic available, but if unable to take it for medical reasons, the $30 copay applies) 100% after $50 copay for non-preferred brand ($60 if generic available, but if unable to take it for medical reasons, the $50 copay applies)	100% after $20 copay for generic 100% after $40 copay for preferred brand 100% after $60 copay for non-preferred brand
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc. per plan schedule; immunizations for travel aren't covered)	100% network 60% non-network	100% network 70% non-network	100% after $20 copay/visit
Radiation therapy, chemotherapy and respiratory therapy	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit
Reconstructive services (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from mastectomy, including lymphedema; call plans for more information)	80% network 60% non-network	90% network 70% non-network	100% depending on services provided; copays may apply (including $200 copay/ admission if hospital care required)

Feature/Covered Expense	KingCare℠ Basic	KingCare℠ Preferred	Group Health
Rehabilitative services Inpatient and outpatient	80% network 60% non-network Up to 60 days/year for inpatient; up to 60 visits/all therapies combined for outpatient (progress review every 20 visits for non-network outpatient)	90% network 70% non-network Up to 60 days/year for inpatient; up to 60 visits/all therapies combined for outpatient (progress review every 20 visits for non-network outpatient)	100% for inpatient services after $200 copay/admission up to 60 days/year (combined with neurodevelopmental therapy) 100% after $20 copay/visit for outpatient services up to 60 visits/year (combined with neurodevelopmental therapy)
Skilled nursing facility	80% network when preauthorized 60% non-network when preauthorized	90% network when preauthorized 70% non-network when preauthorized	100% up to 60 days/calendar year at a Group Health-approved nursing facility
Smoking cessation	100% network services 60% non-network services Prescription drugs to ease nicotine withdrawal, inhalers and sprays covered by Caremark at 100% (no copay); non-prescription nicotine patches and gum covered by Aetna at 100%	100% network services 70% non-network services Prescription drugs to ease nicotine withdrawal, inhalers and sprays covered by Caremark at 100% (no copay); non-prescription nicotine patches and gum covered by Aetna at 100%	100% for 1 Group Health network provider program/year 1 course of nicotine replacement/year (prescription benefit copay applies) when prescribed by Group Health network provider if the member is actively participating in Free and Clear Program
Transplants (certain services only)	100% network when preauthorized 60% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare℠ plan – whether preexisting or an emergency	100% network when preauthorized 70% non-network when preauthorized Medical coverage must have been continuous for more than 12 months under a KingCare℠ plan – whether preexisting or an emergency	100% after applicable copays Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or an emergency
Urgent care (ear infections, high fevers, minor burns, etc.)	80% network 60% non-network	90% network 70% non-network	100% after $20 copay/visit

3 Dental

The dental coverage you have now is shown on your OE form. Dental coverage is provided by Washington Dental Service (WDS). If you want to change your coverage, check the appropriate boxes.

To elect dental coverage, you must elect medical coverage; you cannot elect dental by itself. However, you don't have to elect family medical to elect family dental; you may elect medical for only yourself and elect any combination of family dental coverage.

The following table shows the monthly premiums for the WDS plan. 2006 and 2005 premiums are shown so you can see how premiums compare year to year.

Sp = Spouse DP = Domestic Partner Ch = Children

Monthly Premiums	You Only	You + Sp/DP	You + Ch	All
Washington Dental Service				
2006 ($ 30.56 paid by county)	$ 30.56	$ 91.68	$ 79.46	$ 140.58
2005 ($ 30.54 paid by county)	$ 30.54	$ 91.62	$ 79.41	$ 140.49

The next table summarizes the covered expenses of the WDS plan. You can use any dentist you want, but the benefits are generally higher (your out-of-pocket expenses are less) and the dentist automatically files your claim if you see a WDS dentist (most dentists in Washington participate in the WDS plan).

WDS increases your payment levels through an incentive program as long as you see your dentist for a covered benefit each year:

- For diagnostic and preventive services as well as basic services, the payment level starts at 70% and increases 10% in January of each year until you reach 100% (if you do not see the dentist during the calendar year your payment level is reduced to the next lower payment level, but never below 70%)
- For major restorative services the payment level increases from 70% to 80%, then to 85%.

Washington Dental Service	
Annual deductible (doesn't apply to diagnostic and preventive services, orthodontic services or accidental injuries)	$25/person, $75/family
Annual maximum benefit (doesn't apply to orthodontic or TMJ services)	$2,000/person
Covered Expense	**WDS Pays**
Diagnostic and preventive services (exams, cleanings and x-rays)	70%-100% based on patient's incentive level (deductible doesn't apply)
Basic services (crowns, extractions, fillings, etc.)	70%-100% based on patient's incentive level
Major services – restorative (crowns and onlays)	70%-85% based on patient's incentive level
Major services – prosthodontics (dentures, fixed bridges and implants)	70% (incentive levels do not apply)
Orthodontic services for adults and children	50% up to a $2,500 lifetime maximum (deductible and incentive levels do not apply; benefit doesn't apply to the annual maximum benefit)
Night (occlusal) guards	50% (incentive levels do not apply; your medical plan may provide additional coverage)
Temporomandibular joint (TMJ) disorders	50% up to a $500 lifetime maximum for non-surgical treatment and appliances (incentive levels do not apply and this benefit doesn't apply to the annual maximum benefit; your medical plan may provide additional coverage)
Accidental injury	100% for covered expenses incurred within 180 days of accident (deductible doesn't apply)

4 Vision

The vision coverage you have now is shown on your OE form. Vision coverage is provided by Vision Service Plan (VSP). If you want to change your coverage, check the appropriate boxes.

The following table shows the monthly premiums for the VSP plan. 2006 and 2005 premiums are shown so you can see how premiums compare year to year.

Sp = Spouse DP = Domestic Partner Ch = Children

Monthly Premiums	You Only	You + Sp/DP	You + Ch	All
Vision Service Plan				
2006 ($ 4.88 paid by county)	$ 4.88	$ 14.64	$ 12.69	$ 22.45
2005 ($ 4.79 paid by county)	$ 4.78	$ 14.35	$ 12.43	$ 22.00

The next table summarizes the covered expenses of the VSP plan. You can use any eye care provider you want, but the benefits are generally higher (your out-of-pocket expenses are less) and the provider automatically files your claim if you see a VSP provider.

Vision Service Plan		
Covered Expenses	If you see a VSP provider you pay a $10 copay and the plan pays ...	If you see a non-VSP provider you pay the bill in full and the plan reimburses you the following amounts, minus a maximum $10 copay ...
Exams (once every 12 months)	100%	Up to $40
Lenses (1 pair every 12 months)		
● Single vision	100%	Up to $40
● Bifocal	100%	Up to $60
● Trifocal	100%	Up to $80
● Lenticular	100%	Up to $125
● Polycarbonate for children	100%	Not covered
● Progressive	100%	Up to $5 for upgrade to progressive, tints and coatings combined
● Tints	100%	
● Coatings	100%	
Frames (once every 24 months)	Covered up to $130; if you chose a frame that costs more then the VSP allowable amount, you'll receive 20% off your out-of-pocket costs	Up to $45
Contacts (once every 12 months in place of eyeglass lenses and frames)		
● Elective	100% up to $105	Up to $105
● Medically necessary	100%	Up to $210

5 Life insurance

Your basic life. The county pays for $25,000 basic life insurance for you in 2006 if you elect medical coverage for you. Your current coverage is shown on your form (there are no change options to consider for this benefit). If you die for any reason, your beneficiaries receive $25,000.

Your enhanced life. If you elect medical coverage, you may purchase enhanced life insurance for yourself in $25,000, $50,000, $75,000 or $100,000 amounts when you first enroll in the Partial Benefits Plan or within 30 days of a qualifying event:

- You marry/establish a domestic partnership
- Your child first becomes eligible for coverage under your county benefit plans
- Your spouse/domestic partner or child loses county or other employer-provided life insurance.

However, if you have previously declined enhanced life, you may not purchase it until a qualifying event occurs.

If you die, your beneficiaries receive your enhanced life in addition to your $25,000 basic life insurance.

During this open enrollment, your only change options are to:

- Elect enhanced life if this is your first opportunity to choose it
- Drop or reduce enhanced life if you have it now (you may not add or increase it during open enrollment unless a qualifying event has occurred within the past 30 days).

The enhanced life you have now and your change options are shown on your OE form. If you drop or reduce your enhanced life with your OE form, the change becomes effective January 1; to drop or reduce it sooner, call 206-684-1556.

If you drop all your enhanced life it automatically drops all enhanced life for your family members; if you drop or reduce it, you may not add or increase it again until a qualifying event occurs.

Spouse/domestic partner enhanced life. If you have enhanced life insurance for yourself, you may cover your spouse/domestic partner at 50% of your enhanced amount when you first enroll in the Partial Benefits Plan or within 30 days of a qualifying event:

- You marry/establish your domestic partnership
- Your spouse/domestic partner loses county or other employer-provided life insurance.

However, if you have previously declined spouse/domestic partner enhanced life, you may not purchase it until a qualifying event occurs.

If your spouse/domestic partner dies, you are the beneficiary.

During this open enrollment, your only change options are to:

- Elect enhanced life for your spouse/domestic partner if this is your first opportunity to choose it
- Drop enhanced life for your spouse/domestic partner if you have it now (you may not add or increase it during open enrollment unless a qualifying event has occurred within the past 30 days).

The spouse/domestic partner enhanced life you have now and your change options are shown on your OE form. If you drop spouse/domestic partner enhanced life with your OE form, the change becomes effective January 1; to drop it sooner, call 206-684-1556.

If you drop spouse/domestic partner enhanced life, you may not add it again until a qualifying event occurs.

Children enhanced life. If you have enhanced life insurance for yourself, you may cover each of your children 14 days or older for $10,000 each when you first enroll in the Partial Benefits Plan or within 30 days of a qualifying event:

- Your child first becomes eligible for coverage under your county benefit plans
- Your child loses county or other employer-provided life insurance.

However, if you have previously declined children enhanced life, you may not purchase it until a qualifying event occurs.

If your child dies, you are the beneficiary.

During this open enrollment, your only change options are to:

- Elect enhanced life for your children if this is your first opportunity to choose it
- Drop enhanced life for your children if you have it now (you may not add or increase it during open enrollment unless a qualifying event has occurred within the past 30 days).

The children enhanced life you have now and your change options are shown on your OE form. If you drop children enhanced life with your OE form, the change becomes effective January 1; to drop it sooner, call 206-684-1556.

If you drop children enhanced life, you may not add it again until a qualifying event occurs.

More about enhanced life, including cost. Life insurance is provided through Aetna and is portable. If you terminate employment with the county (but not if you leave employment due to disability), you may continue to pay Aetna directly for the basic and enhanced coverage you had on your last day of employment until you reach age 99. If you continue the coverage for yourself, you may continue the enhanced coverage you had for your spouse/domestic partner until he/she is 65 up to $25,000 and your dependent children until they're 19 (23 if solely dependent on you for support) up to $5,000. The age-specific rates you pay for the continued coverage may be different from the rates paid by active employees.

The monthly cost of enhanced life insurance for you and your spouse/domestic partner is based on your age; cost for all children is $.84, regardless of the number of children covered.

The following table shows the cost of enhanced life per $25,000 for different age groups. A worksheet is included so you can calculate your total monthly cost.

Your Age	Cost of Enhanced Life/$25,000
Under 25	$ .88
25-29	$ 1.05
30-34	$ 1.40
35-39	$ 1.40
40-44	$ 1.78
45-49	$ 2.83
50-54	$ 4.23
55-59	$ 7.55
60-64	$ 11.60
65-69	$ 19.93
70+	$ 32.33

To calculate your total monthly cost for enhanced life ...

Enter cost/$25,000 for your age here	1. $	_____
If you have $25,000 for yourself, enter 1 here If you have $50,000 for yourself, enter 2 here If you have $75,000 for yourself, enter 3 here If you have $100,000 for yourself, enter 4 here	2.	_____
Multiply line 1 by line 2 and enter the answer here	3. $	_____
If you elect enhanced life for your spouse/DP enter .5 here; if not, enter 0	4. $	_____
Multiply line 3 by line 4 and enter the cost of enhanced life for your spouse/DP here	5. $	_____
If you elect enhanced life for children enter $.84 here; if not, enter 0	6. $	_____
Add lines 3, 5 and 6 for your total monthly cost here →	$	_____

6 AD&D insurance

Your basic AD&D. The county pays for $25,000 basic accidental death and dismemberment (AD&D) insurance for you in 2006 if you elect medical coverage for you. Your current coverage is shown on your form (there are no change options to consider for this benefit). If you die in a covered accident, your beneficiaries receive $25,000 (in addition to your basic life insurance benefit). For dismemberment, paralysis and other covered losses, you receive an amount determined by the type of loss.

Your enhanced AD&D. If you elect medical coverage, you may purchase enhanced AD&D insurance for yourself from $50,000 to $500,000, in $50,000 increments, when you first enroll in the Partial Benefits Plan or during open enrollment. If you die, your beneficiaries receive your enhanced AD&D in addition to your $25,000 basic AD&D insurance.

During open enrollment, you may add, increase, drop or reduce your enhanced AD&D. The enhanced AD&D you have now and your change options are shown on your OE form. If you make a change with your OE form, the change becomes effective January 1; to drop or reduce enhanced AD&D sooner, call 206-684-1556.

If you drop all your enhanced AD&D it automatically drops all enhanced AD&D for your family members; if you drop or reduce it, you may not add or increase it again until the next open enrollment.

Spouse/domestic partner enhanced AD&D. If you have enhanced AD&D insurance for yourself, you may cover your spouse/domestic partner at 50% or 100% of your enhanced amount when you first enroll in the Partial Benefits Plan, during open enrollment or within 30 days of a qualifying event:

- You marry/establish a domestic partnership
- Your spouse/domestic partner loses county or other employer-provided AD&D insurance.

If your spouse/domestic partner dies or is dismembered in a covered accident, you are the beneficiary.

During open enrollment, you may add, increase, reduce or drop spouse/domestic partner enhanced AD&D. The spouse/domestic partner enhanced AD&D you have now and your change options are shown on your OE form. If you make a change with your OE form, the change becomes effective January 1; to drop or reduce spouse/domestic partner enhanced AD&D sooner, call 206-684-1556.

If you drop or reduce spouse/domestic partner enhanced AD&D, you may not add or increase it again until the next open enrollment or a qualifying event occurs (provided you have enhanced AD&D for yourself when the event occurs).

Children enhanced AD&D. If you have enhanced AD&D insurance for yourself, you may cover each of your children for 10% of your enhanced amount when you first enroll in the Partial Benefits Plan, during open enrollment or within 30 days of a qualifying event:

- Your child first becomes eligible for coverage under your county benefit plans
- Your child loses county or other employer-provided AD&D insurance.

If your child dies or is dismembered in a covered accident, you are the beneficiary.

During open enrollment, you may add or drop children enhanced AD&D. The children enhanced AD&D you have now and your change options are shown on your OE form. If you make a change with your OE form, the change becomes effective January 1; to drop children enhanced AD&D sooner, call 206-684-1556.

If you drop children enhanced AD&D, you may not add it again until the next open enrollment or a qualifying event occurs (provided you have enhanced AD&D for yourself when the event occurs).

Cost of enhanced AD&D. AD&D insurance is provided through CIGNA. The monthly cost of enhanced AD&D insurance is the same in 2006 as in 2005. Add across each row for those you cover to determine your total monthly cost.

If you elect this enhanced amount ...	Monthly Cost for You	Monthly Cost to Cover Your Spouse/DP at 50% of Your Amount	Monthly Cost to Cover Your Spouse/DP at 100% of Your Amount	Monthly Cost to Cover All Your Children at 10% of Your Amount
$ 50,000	$ 1.00	$ .50	$ 1.00	$ .30
$ 100,000	$ 2.00	$ 1.00	$ 2.00	$ .60
$ 150,000	$ 3.00	$ 1.50	$ 3.00	$ .90
$ 200,000	$ 4.00	$ 2.00	$ 4.00	$ 1.20
$ 250,000	$ 5.00	$ 2.50	$ 5.00	$ 1.50
$ 300,000	$ 6.00	$ 3.00	$ 6.00	$ 1.80
$ 350,000	$ 7.00	$ 3.50	$ 7.00	$ 2.10
$ 400,000	$ 8.00	$ 4.00	$ 8.00	$ 2.40
$ 450,000	$ 9.00	$ 4.50	$ 9.00	$ 2.70
$ 500,000	$ 10.00	$ 5.00	$ 10.00	$ 3.00

7 LTD insurance

The county pays for basic long term disability for you if you elect medical coverage for yourself. If you become disabled, are unable to work and apply for LTD, this benefit combines with other sources of disability income to replace 60% of your monthly predisability earnings to a maximum benefit of $6,000 a month after a 180-day waiting period.

You may purchase enhanced LTD only when you first enroll in the Partial Benefits Plan (if you have previously declined enhanced LTD, you do not have the option to purchase it). Enhanced LTD increases the maximum benefit to $7,200 a month and reduces the waiting period to 90 days.

During this open enrollment, your only change options are to:
- Elect enhanced LTD if this is your first opportunity to choose it
- Drop enhanced LTD if you have it now.

The LTD you have now (basic or enhanced) and your change options are shown on your OE form. If you drop enhanced LTD with your OE form, the change becomes effective January 1; to drop it sooner, call 206-684-1556. Once you drop enhanced LTD, you may not add it back again.

The cost for enhanced LTD is $4.53 a month.

8 Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA you do not pay federal or Social Security (FICA) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

- Health Care FSAs allow you to set aside pretax dollars to pay for certain expenses not covered by your medical, dental and vision plans (for example, copays for office visits and the cost of orthodontia not fully paid by your dental plan).
- Dependent Care FSAs allow you to set aside pretax dollars to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent while you and your spouse work.

See the separate FSA Guide for more details and an FSA Enrollment Form. If you want to enroll in an FSA beginning January 1, 2006, or are currently enrolled and want to continue participating in 2006 (you must re-enroll each year to continue participating), complete the FSA Enrollment Form and return it to Benefits and Retirement Operations (the address is on the form) *by Friday, October 28.*

9 State retirement

If you were enrolled in the Public Employees Retirement System Plan 2 before September 1, 2002, and remain in PERS Plan 2, you are considered a "grandfathered PERS 2 member" and are given the opportunity to transfer from PERS Plan 2 to PERS Plan 3 every year at open enrollment.

Information about PERS Plan 3 is available from the Washington State Department of Retirement Systems:

- On the Internet – www.drs.wa.gov/member/plans/PERS/default.htm
- By phone – 1-800-547-6657 (TTY 1-866-377-8895)
- By e-mail – recep@drs.wa.gov.

To transfer from PERS Plan 2 to PERS Plan 3, complete the Member Information Form available at www.drs.wa.gov/forms/member/memberinformationform.pdf or from Benefits and Retirement Operations (call 206-684-1556) and return it to Benefits and Retirement Operations *in January 2006* (the form must be signed and dated after January 1 and received before close of business January 31). The transfer becomes effective February 2006, provided you're an active employee and earn service credit in January. Once you decide to transfer, the decision is irrevocable after February 1; you cannot return to PERS Plan 2.

If you do not want to transfer (you want to remain in PERS Plan 2), do nothing; you will be given the opportunity to transfer again during next year's open enrollment.

10 Covered family members

This section of your OE form shows the family members you now cover under your benefit plans. To add or drop family members, see the sections on the back of your form; to correct any information that's missing or wrong, write the correct information on the front of your OE form and return it.

11 Insurance beneficiaries

This section of your OE form shows the beneficiaries you've designated to receive your insurance death benefits if you have basic life insurance.

Due to programming/printing limitations in producing the OE form, the benefit percentage for each beneficiary listed has been rounded and may not reflect the precise amount you assigned on your Beneficiary Designation Form. However, should you die, each beneficiary will receive the amount you assigned on your form.

To change or correct any beneficiary information, you must complete and return a new Beneficiary Designation Form – *do not make corrections on your OE form.* A Beneficiary Designation Form is included in your OE packet. Return it to Benefits and Retirement Operations.

12 Sign to authorize changes

If you've made any changes on your OE form, you must sign the form to authorize them. Otherwise, the changes can't be made.

13 Add family members

The following family members are eligible for coverage under your benefit plans if you enroll them:

- Your spouse/domestic partner (copy of marriage certificate or Affidavit of Marriage/Domestic Partnership must be filed with Benefits and Retirement Operations)
- Unmarried children of you or your spouse/domestic partner if they are under age 23 and chiefly dependent on you for support and maintenance; they may be your:
  - Natural children
  - Adopted children (or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption; attach appropriate documentation)
  - Stepchildren
  - Legally designated wards (legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order; attach appropriate documentation).

Parents and other relatives who are not members of your immediate family are not eligible for coverage under your benefit plans.

To add family members, provide all information in this section of your OE form, including complete Social Security numbers (to protect your privacy, no or only the last four digits of Social Security numbers are used when Benefits and Retirement Operations corresponds with you, but complete Social Security numbers are required if you add family members for benefit coverage).

If you add family members with your OE form, their coverage becomes effective January 1, 2006. However, if you currently have Partial Benefits Plan coverage and are adding them within 30 days of a qualifying event (for example, birth, adoption, placement of a legal ward, marriage or establishment of a domestic partnership, significant change in your spouse's/domestic partner's employer-sponsored coverage, etc.), you may add them sooner using an Add Family Member form available at www.metrokc.gov/employees/benefits or from Benefits and Retirement Operations.

Tax implications for domestic partner health coverage. There is no cost to cover family members, but when you cover a domestic partner (DP) and his/her children for health benefits (medical, dental, vision) the IRS taxes you on the value of the coverage. This value is added to the salary shown on your paycheck (and W-2 at the end of the year), federal income and Social Security (FICA) taxes are withheld on the higher salary amount, then the value is subtracted from your salary.

You may want to add a domestic partner and his/her children for enhanced life/AD&D without adding them for the "taxable" health benefits. If that's the case, list the family member in the "Add family members" section on the back of your open enrollment form and write "Add for life/AD&D only" next to the name.

Taxable values for the different combinations of health plans are shown below.

Monthly Taxable Value of Health Plans	DP Only		DP's Children		DP + DP's Children	
	2006	2005	2006	2005	2006	2005
KingCare℠ Basic + Dental + Vision	$ 429.41	$ 408.25	$ 343.54	$ 326.60	$ 772.95	$ 734.85
KingCare℠ Preferred + Dental + Vision	$ 496.70	$ 471.92	$ 397.37	$ 377.53	$ 894.07	$ 849.45
Group Health + Dental + Vision	$ 382.30	$ 381.84	$ 305.85	$304.87	$ 688.15	$ 686.71
Dental + Vision Only (Opted Out of Medical)	$ 70.88	$ 70.65	$ 56.71	$ 56.52	$ 127.59	$ 127.17

14 Affidavit

If you add a new (not previously covered) spouse/domestic partner for benefit coverage, you must complete this section of your OE form and both you and your spouse/domestic partner must sign. Otherwise, your spouse/ domestic partner will not be added for coverage.

15 Drop family members

To drop currently covered family members, provide all information in this section of your OE form. Include the date the qualifying event occurred (when dropped family member was no longer eligible for coverage) and the dropped family member's mailing address for COBRA notification, as required by law. Family members will be dropped based on qualifying event dates, not January 1, 2006.

Resource Directory

If no TTY phone number is listed, please call 711 to access the TTY Relay Service.

For Questions About ...	Contact ...
AD&D Insurance ● Conversion when you leave employment ● Secure travel benefits ● For claims, contact Benefits and Retirement Operations	CIGNA Phone 1-800-441-1832 (conversion) ▪ 1-800-552-5744 (TTY) Worldwide Assistance Services Inc. (secure travel benefits) Phone 1-888-226-4567 (US/Canada) ▪ Call collect 202-331-7635 (all other locations) Fax 202-331-1528 E-mail cigna@worldwideassistance.com
Benefit Eligibility for Partial Benefits Plan and Full Benefits Plan	Your Base Chief

For Questions About ...	Contact ...
Benefits – General ● Eligibility ● Open enrollment and making changes ● Flexible Spending Account enrollment ● Life, AD&D and LTD insurance plan details ● Alternate formats	Benefits and Retirement Operations Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104-1598 Phone 206-684-1556 ▪ 1-800-325-6165 x41556 (outside local calling area) Fax 206-684-1925 E-mail kc.benefits@metrokc.gov Web www.metrokc.gov/employees/benefits
Dental ● Providers ● Claims and appeals ● Other plan details	Washington Dental Service (WDS) PO Box 75983, Seattle WA 98175-0983 Phone 206-522-2300 ▪ 1-800-554-1907 E-mail cservice@deltadentalwa.com Web www.deltadentalwa.com
Flexible Spending Accounts (FSAs) ● Account balances ● Reimbursement ● Other plan details	Personal Choice Account (PCA) offered by Regence BlueCross and BlueShield of Oregon (formerly Associated Administrators Inc.) The Personal Choice Account PO Box 3199, Portland OR 97208-3199 Phone 1-800-334-4340 Fax 1-800-979-8987 E-mail pca@regence.com Web www.personalchoiceaccount.com
Life Insurance ● Conversion or portability option when you leave employment ● Evidence of Insurability (EOI) ● For claims, contact Benefits and Retirement Operations	Aetna Phone 1-800-826-7448 (conversion/portability) ▪ 1-800-523-5065 (EOI)
LTD Insurance ● Conversion option when you leave employment ● Claims and appeals	CIGNA Phone 1-800-441-1832 (conversion) ▪ 1-800-781-2006 (claims) 1-800-336-2485 (TTY) Web www.cigna.com/consumer/forms/disability/disability_claim.html
Medical – General ● Providers (doctors, hospitals, etc.) ● Claims and appeals ● Identification cards ● Preauthorization ● Other plan details (covered expenses, limitations, exclusions)	KingCare℠ – Aetna PO Box 14089, Lexington KY 40512-4089 Phone 1-800-654-3250 ▪ 1-800-628-3323 (TTY) E-mail kingcare@aetna.com Web www.kingcare.com Medical Claims – Aetna Inc., Attn: National Accounts CRT PO Box 14463, Lexington KY 40512 Fax 1-817-417-2026 Group Health Cooperative PO Box 34585, Seattle WA 98124-1585 Phone 1-888-901-4636 ▪ 1-800-833-6388 (TTY) E-mail info@ghc.org Web www.ghc.org

For Questions About ...	Contact ...
Medical – Prescriptions ● Drug formulary (covered drugs, including generic, preferred brand and non-preferred brand) ● Pharmacies ● Mail order service ● Filing claims and appeals ● Identification cards (KingCare℠ members only; Group Health members use medical plan card for prescriptions)	KingCare℠ –Caremark (formerly AdvancePCS) PO Box 52136, Phoenix, AZ 85072-2136 Phone 1-800-552-8159 Web http://kingcounty.advancerx.com (e-mail by selecting Contact Us), or www.caremark.com Rx Claims Appeals – Caremark (formerly AdvancePCS), Attn: Prescription Claim Appeals MC 109 PO Box 52084, Phoenix AZ 85072-2084 Group Health Cooperative PO Box 34585, Seattle WA 98124-1585 Phone 1-800-245-7979 (mail order prescriptions) E-mail info@ghc.org Web www.ghc.org
PERS Plan 2 to PERS Plan 3 Transfer ● General information ● Forms	State of Washington Department of Retirement Systems PO Box 48380, Olympia WA 98504-8380 Phone 1-800-547-6657 ▪ 1-866-377-8895 (TTY) E-mail recep@drs.wa.gov Web www.drs.wa.gov/member/plans/PERS/default.htm
Vision ● Providers ● Claims and appeals ● Other plan details	Vision Service Plan PO Box 997100, Sacramento CA 95899-7100 Phone 1-800-877-7195 ▪ 1-800-428-4838 (TTY) Web www.vsp.com (e-mail through the site)